CMS Interim Procedural Guidance for Assessing Home and Community-Based (HCBS) Waiver Programs

Purpose

The purpose of this document is to update the ***Interim Procedural Guidance ("Guidance")*** to CMS staff responsible for assessing State Medicaid HCBS waivers. This ***Guidance*** supercedes that provided in Version 1.2 of *The Protocol*[1] *and the January 23rd, 2004 Memo from Glenn Stanton, Acting Director of the Disabled and Elderly Health Programs Group (DEHPG*) which transmitted the first ***Interim Procedural Guidance***. This ***Guidance*** is effective for all 1915 (c) waiver programs immediately and until such time as it is modified or replaced.

This *Guidance* will be operational during the time that CMS transitions its quality oversight approach to one that incorporates both the assurance of statutory requirements and promotion of quality improvement. The *Guidance* is one of several components of CMS's renewed approach to quality (as depicted in ***Diagram A – The HCBS Waiver Quality Life Cycle***).

CMS has the responsibility to assess each HCBS waiver to determine the adequacy of the state's management and oversight of the program, including whether the state meets the waiver assurances. It is CMS' intent to issue a written report on its assessment to the state prior to the expiration of the waiver. It is also CMS' intent to issue the report in sufficient time to allow a state to make any changes and improvements that CMS deems necessary before it can act favorably on the state's waiver renewal application.

In its oversight role CMS will focus on each state's system to assure and improve quality. As such, CMS' approach will use information provided by the states, derived from their [states'] internal self-monitoring activities, as a primary source of information. This approach provides a more efficient and effective assessment of waiver programs by CMS.

Procedural Guidance for Assessing Waiver Programs

1. Issuing the Standard Letter with Information Request to States

[1] HCFA Regional Office Protocol for Conducting Full Reviews of State Medicaid Home and Community-Based Waiver Programs, Version 1.2, December 20, 2000

The CMS Regional Office should issue the ***Standard Letter from the Regional Office to State Medicaid Director (including Request for Evidentiary-Based Information)*** **(*Attachment A*)** to the state no later than **eighteen months** prior to the expiration date of the waiver. This time frame will allow sufficient time for the state to respond to the request for information, for CMS waiver analysts to review the information provided by the state, and for the state to make modifications/improvements requested by CMS prior to submitting a waiver renewal application.

CMS Regional Office staff may find that follow-up contact with the state is necessary for discussing the information request or the nature of the evidence that the state is to provide. The Regional Office may also find they will need to assist states that do not have information readily available, and to determine whether and which information the state may be able to assemble within the time frame allowed. The ***Guide for Assisting States in Identifying Evidence***[2] ***(Attachment B***) is a tool that CMS staff may use to assist states in identifying their discovery practices and the kinds of information available from their quality management systems. States can likewise use this tool to inform their self-assessment activities.

2. Reviewing Information Provided by States

The CMS waiver analyst reviews the information provided by the state in response to CMS' request for information. This information should augment information garnered by CMS in the years preceding the request for data through its ongoing dialogue/communication on waiver quality management with the state ***(Attachment C – CMS Ongoing Dialogue with States on Waiver Quality*)**. The ongoing communication between CMS and the states may take many forms and provides relevant information about a state's operation of a waiver program. It will include, among other information, yearly CMS-372 reports.

After reviewing information submitted by the state (in conjunction with information provided by prior dialogue/communication with the state), the CMS analyst may conclude that additional information is necessary from the state before s/he can make a reasonable determination of whether the state has met the assurances. The waiver analyst may obtain information from the state over the phone and confirm it through e-mail or correspondence. If the state is not able to produce the information sought by the analyst, s/he may request the state to gather the evidence necessary toward documenting that an assurance(s) was met; this may necessitate the state conducting a review of participants and providers.

The CMS analyst may find it helpful to address the following questions when reviewing the status of a state waiver program and the information provided by the state. The ***Work Sheet for Reviewing States' Evidentiary Information (Attachment D***) may be used to summarize and record conclusions.

[2] Formerly known as the *"Probing Questions"*.

a) Does the program have any known problems indicative of substantial non-compliance with required state assurances?

b) Have there been *significant* changes in the approved waiver e.g., change in operational structure, change in policies and procedures affecting program compliance with Medicaid assurances, change in utilization patterns and/or expenditures, change in enrollment, change in eligibility criteria? The CMS waiver analyst may find changes of a problematic and/or positive nature; both types of significant changes should be noted.

c) Are the CMS-372 reports filed in a timely manner and is the content acceptable? Criteria for what is acceptable includes:
   - submission of accurate data,
   - demonstrated compliance with approved cost and utilization limits,
   - documentation of problem resolution, both in terms of individuals affected and systemic modifications to prevent problem recurrence in the future.

3. Collecting Information Directly (CMS On-Site Visit)

In some instances, when the state is unable to provide the information necessary for the analyst to determine that an assurance(s) has been met, CMS Regional Office staff may conclude that an on-site visit to the state is necessary to obtain information directly. Before a CMS Regional Office may conduct an on-site visit to a state, it must first consult with the CMS Central Office regarding the nature of the site visit. (Please see below for "**Conditions That Require Additional CMS Assessment Activities".)**

4. Making a Determination About the Assurances

Using the standard ***Findings Report Template (Attachment E***), the CMS Regional Office must document whether the state substantially meets each of the six (6) assurances. To make this determination, CMS must rely upon the evidence that the state provides and/or the information it collects and/or observations made. CMS should rely on information gathered as part of the formal assessment as well as information provided in CMS-372 reports and information garnered as a result of its ongoing dialogue/communication with the states over the course of the waiver's life. The report template provides space for the waiver analyst to summarize the evidence related to each assurance that supports its determination (i.e., met or not met).

By determining that an assurance is "substantially met", CMS signifies that it has found evidence that the state:

- Has an adequate and effective system(s) for meeting the assurance; and
- Demonstrates ongoing and systematic oversight appropriate to the specific assurance.

While a state may meet the above criteria and thus "substantially meet" a given assurance, the CMS may also conclude that the state should implement improvements. The waiver analyst should use the "Recommendations" section of the report template to specify the nature of recommended improvements. S/he should use this section of the template, under each assurance, to communicate to the state the time frame within which CMS suggests the improvements be initiated/accomplished and any contingencies for the renewal application related to the recommended improvements.

In concluding that an assurance is "substantially not met", CMS indicates that it has found evidence that the state:

- Demonstrated a pervasive failure to meet the assurance; and
- Has no internal plan of correction.

When CMS determines an assurance has not been met, it must provide specific written recommendations to the state for system improvements and a timeframe for initiating/accomplishing the improvements. The recommendations section of the report must also specify CMS's expectations regarding improvements that must be achieved prior to approval of any waiver renewal application.

5. Issuing the Draft Report to the State

Using the **Findings Report Template,** the CMS Regional Office should issue a standard Draft Report to the state **twelve months** prior to the expiration date of the waiver. This time frame will allow adequate time for the state to comment on CMS's findings and make required improvements to the waiver program prior to submission of the renewal application. The ***Findings Report Template*** conveys the findings of the review, including summarized evidence for the findings and recommendations for improvement to the state.

6. Issuing the Final Report

Using the **Findings Report Template,** the CMS Regional Office should issue a standard Final Report to the State **within 60 days of receipt of the state's response to the draft findings report**. The Final Report should either incorporate the state's response or the state's response should be attached to the Final Report. The Final Report should be sent to the State Medicaid Agency with a copy to the State Operating Agency (as applicable) and the CMS Central Office waiver analyst.

Conditions That Require Additional CMS Assessment Activities

There are three conditions that, separately or in conjunction with each other, indicate the need for additional or more extensive assessment activities by CMS staff:

1. The state is unable to provide information related to <u>any</u> of the assurances as

requested in the Standard Letter.

2. CMS, through the 372 reports or other mechanisms, has detected serious problems with the state's management of the waiver and ability to meet the waiver assurances. For example, there may have been adverse media publicity that reflects in a plausible manner on the program's inability to meet the Medicaid assurances.

3. The waiver is operating under sanctions or restrictions imposed by CMS, the State Medicaid Agency or any other Federal or State governmental entity.

Assessment activities may include: inspection of records; interviews with participants, providers, advocates; on-site observations of service delivery; a financial audit; a special focused review or other similar and appropriate review activities**.** Before a CMS Regional Office may conduct an on-site visit to a state, it must first consult with the CMS Central Office regarding the nature of the site visit.